General Assembly

Committee Bill No. 6652

January Session, 2007

LCO No. **4877**

04877HB06652INS

Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

AN ACT ESTABLISHING THE CONNECTICUT HEALTHY STEPS PROGRAM.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective July 1, 2007*) This act shall be known as the Connecticut Healthy Steps Program.

Sec. 2. (NEW) (*Effective July 1, 2007*) (a) There is established a permanent Health Care Reform Commission, which shall be an independent body within the Office of Health Care Access for administrative purposes only. Said commission shall: (1) Not later than July 1, 2008, develop an affordable health care plan, which shall serve as the benchmark health care plan that an employer shall make available to employees to qualify for a tax credit in accordance with section 6 of this act and which may be sold to employers with fifty or fewer employees through the Connecticut Connector, (2) not later than July 1, 2008, develop a model enhanced health care plan, which shall be a comprehensive health care plan, as described in section 38a-555 of the general statutes, and shall serve as the benchmark health care plan that an employer shall make available to employees to qualify for a tax credit in accordance with section 7 of this act, (3) not later than January

1, 2009, submit a report to the joint standing committee of the General Assembly having cognizance of matters relating to insurance that identifies the effect of health insurance mandates under chapter 700c of the general statutes on health care premiums paid by private sector employers, (4) develop incentives to encourage individuals to use health insurance responsibly, (5) develop a proposed plan and timetable for the implementation of state-wide electronic prescribing, computerized physician order entry in every hospital, and a uniform electronic medical record system that will improve the quality of health care in the state, (6) plan for the implementation of a pharmaceutical purchasing pool to be administered by a third-party administrator to cover all public employees and public programs, and (7) not later than January 1, 2009, and annually thereafter, make recommendations to the General Assembly concerning the implementation of the Connecticut Healthy Steps Program and improvements to the health care system, including cost controls.

(b) The commission shall consist of the Commissioners of Social Services and Health Care Access, the Insurance Commissioner, or their designees, and nine additional members as follows: One member to be appointed by the Governor, two to be appointed by the president pro tempore of the Senate, two to be appointed by the speaker of the House of Representatives, one to be appointed by the majority leader of the Senate, one to be appointed by the majority leader of the House of Representatives, one to be appointed by the minority leader of the Senate, and one to be appointed by the minority leader of the House of Representatives.

(c) Notwithstanding the provisions of subsection (c) of section 4-9a of the general statutes, the members of the commission shall serve for staggered terms. The initial members selected shall serve as follows: (1) The members appointed by the Governor and the president pro tempore of the Senate shall serve for three years; (2) the members appointed by the speaker of the House of Representatives and the majority leader of the Senate shall serve for two years; and (3) the

members appointed by the majority leader and the minority leader of the House of Representatives and the minority leader of the Senate shall serve for one year. Following the expiration of such initial terms, each subsequent appointee shall serve for a term of three years. Any vacancy shall be filled by the appointing authority for the unexpired portion of the term of the member replaced. The members shall serve without compensation for their services but shall be reimbursed for their expenses.

(d) The commission shall meet as often as necessary to complete its work, but not less than quarterly each year. The commission, within available appropriations, may hire consultants to provide assistance with its responsibilities.

Sec. 3. (NEW) (*Effective July 1, 2007*) (a) The Insurance Department, in consultation with the Health Care Reform Commission, shall develop and issue a request for proposals in accordance with the provisions of sections 4-212 to 4-219, inclusive, of the general statutes and award a five-year year contract to administer the Connecticut Connector. Such contract shall be awarded to a private nonprofit organization which shall serve as a health insurance purchasing pool, through which previously uninsured individuals and uninsured small employers may purchase health plans. Such organization shall be known as the Connecticut Connector.

(b) Such organization shall meet with the Health Care Reform Commission in accordance with a schedule the commission determines to be appropriate.

(c) Such organization shall perform the following duties:

(1) Solicit insurers to make products available for sale through the Connecticut Connector;

(2) Review the products for compliance with benefit and other standards as established by the Health Care Reform Commission;

(3) Publish easy to understand materials for prospective purchasers, comparing the costs and benefits of all plans and providing counseling to assist in plan selection;

(4) Screen applicants consisting of individuals and small employers for eligibility to purchase through the pool;

(5) Work with the insurers selling products through the Connecticut Connector to develop a uniform tool for collecting necessary applicant or enrollee data for any appropriate underwriting, enrollment and other purposes;

(6) Collect premium contributions from employers and individuals, as well as subsidies from the state, and remit them to the enrollees' health plans;

(7) Collect fees from each insurer that sells products through the Connecticut Connector, in accordance with rules adopted by the Health Care Reform Commission, to support the costs of administration;

(8) Notify insureds when their premiums are late and disenroll them or levy late penalties as appropriate;

(9) Provide notices as required under the Health Insurance Portability and Accountability Act of 1996, (P.L. 104-191) (HIPAA), as from time to time amended, regarding creditable coverage;

(10) Market the health plans available though the Connecticut Connector to potential purchasers of the health plans;

(11) Administer the programs in accordance with sections 7 and 8 of this act;

(12) Receive moneys from the Comptroller and make payments to eligible individuals and small employers in accordance with sections 10 and 11 of this act;

(13) Not later than July 1, 2009, and annually thereafter, provide data and reports to the Health Care Reform Commission and the General Assembly, which shall include, but not be limited to (A) the number and demographics of previously uninsured persons covered through the Connecticut Connector by type of policy, (B) the per capita administrative costs of the Connecticut Connector, (C) any recommendations for improving service, health insurance policy offerings and costs, and (D) any other information as required by said commission.

Sec. 4. (NEW) (*Effective July 1, 2007*) (a) The organization that administers the Connecticut Connector shall make available to each applicant seeking enrollment in the program a choice of three health insurance plan types as follows: (1) An affordable health care plan established in accordance with standards established by the Health Care Reform Commission; (2) a comprehensive health care plan currently available from insurers at the option of such insurers; and (3) a health savings account plus high deductible plan currently available from insurers at the option of such insurers.

(b) The affordable health care plan shall include, but not be limited to:

(1) Coverage of any physician, clinic, ambulatory surgery, laboratory and diagnostic services, in-patient and out-patient hospital care and prescription drugs that are medically necessary for physical or mental health;

(2) Coinsurance that shall reflect family income brackets;

(3) A copayment not to exceed seventy-five dollars for inappropriate use of the emergency department of a hospital;

(4) A lifetime benefits maximum in the amount of five hundred thousand dollars, contingent upon the availability of an excess cost reinsurance program through the Department of Social Services for

which an individual or family would become eligible without spending down all of their resources upon exhaustion of their insurance benefit; and

(5) A minimum loss ratio of not less than eighty-five per cent over any three-year moving average period.

(c) Each health care plan offered shall:

(1) Be community-rated based on the individual's age, sex, county of residence and tobacco use; and

(2) Have a medical loss ratio of at least eighty-five per cent.

(d) Coverage under each of the health care plans shall be deemed to be creditable coverage, as defined in 42 USC 300gg(c) and shall preclude any exclusions for preexisting conditions in any subsequent health care plan an individual may obtain.

(e) Each health care plan offered may not cover the preexisting conditions of any individual who has been uninsured for a period exceeding twelve months.

(f) Any small employer that purchases coverage through the program may offer its employees any of the plans described in subsection (a) of this section.

Sec. 5. (NEW) (*Effective July 1, 2007*) (a) An application by an individual to purchase coverage through the Connecticut Connector may be approved in cases in which an individual has no access to employer-sponsored coverage under which the employer pays a minimum of fifty per cent of the cost of such coverage for an individual and their dependents and an individual has been:

(1) Uninsured for a period of at least six months; or

(2) Uninsured for a period of less than six months due to the occurrence of a major life event that has resulted in such uninsured

status, including, but not limited to:

(A) Loss of coverage through the employer, due to termination of employment;

(B) Death of, or abandonment by, a family member who previously provided coverage;

(C) Loss of dependent coverage due to spouse attaining the age of sixty-five years and becoming eligible for Medicare;

(D) Disqualification as a dependent under a group comprehensive health care plan;

(E) Expiration of the coverage periods established by the Consolidated Omnibus Budget Reconciliation Act of 1985, (COBRA) (P.L. 99-272) as amended from time to time;

(F) Extreme economic hardship on the part of either the employee or the employer, as determined by the organization that administers the Connecticut Connector; and

(G) Any other events that may be specified by the Health Care Reform Commission.

(b) An application by a small employer to purchase coverage through the pool may be approved if such employer:

(1) Has fifty or less employees;

(2) Has not offered a comprehensive health insurance plan to any employee for a period of at least six months; and

(3) Will contribute a minimum of seventy per cent of the cost of such coverage for an employee and a minimum of fifty per cent of the cost of dependent coverage for any dependent of such employee.

Sec. 6. (NEW) (*Effective July 1, 2007*) (a) For purposes of this section:

(1) "Employer" means any person, firm, business, educational institution, nonprofit agency, corporation, limited liability company or any other entity which, on at least fifty per cent of its working days during the preceding twelve months, employed not more than fifty eligible employees, the majority of whom were employed within the state of Connecticut, but shall not include the state or any political subdivision of the state;

(2) "Full-time employee" means any person employed by an employer for thirty hours or more a week in a full-time position; and

(3) "Part-time employee" means any person employed by an employer for less than thirty hours a week in a part-time position.

(b) There is hereby established a tax credit to assist employers with providing health insurance to their employees to achieve the goal of ensuring greater access to health insurance for residents of this state. Any employer that elects to claim such tax credit shall submit a copy of its health insurance plan to the Connecticut Connector. If said Connecticut Connector certifies that such plan meets or exceeds the standards for the affordable health care plan established pursuant to section 2 of this act, the Connecticut Connector shall issue a certificate indicating such fact.

(c) (1) There shall be allowed a credit against the tax imposed under chapter 208 and chapter 213a of the general statutes on any corporation or entity subject to either tax, provided such employer (A) has obtained a certificate from the Connecticut Connector in accordance with this section, and (B) pays at least seventy per cent of the cost of an employee's benefits and fifty per cent of the cost of dependents' benefits for full-time employees.

(2) For employers offering such coverage to all full-time employees but not to all part-time employees, the credit shall be in an amount equal to twenty per cent of the cost of providing health care benefits, provided such amount shall not exceed eight hundred dollars per

employee per year in the case of a policy covering an individual employee, one thousand six hundred dollars per employee per year in the case of a policy covering an employee and only one other individual, or two thousand four hundred dollars per employee per year in the case of a policy covering an employee and the family of such employee.

(3) For employers offering such coverage to all full-time and part-time employees, the credit shall be in an amount equal to twenty-five per cent of the cost of providing health care benefits, provided such amount shall not exceed one thousand per employee per year in the case of a policy covering an individual employee, two thousand dollars per employee per year in the case of a policy covering an employee and only one other individual, or three thousand dollars per employee per year in the case of a policy covering an employee and the family of such employee.

(4) In the event the employer owes less than the value of the credit allowed under this subsection, the employer shall be entitled to a refund from the state in an amount equal to the amount of the unused credit.

(d) An employer qualifying under subsection (c) of this section that is a limited liability company, limited liability partnership, limited partnership or S corporation, as defined in section 12-284b of the general statutes, may distribute a credit to its members and such members shall be eligible to use such credit against the tax imposed under chapter 229 of the general statutes. The total credit that may be distributed shall not be greater than the following:

(1) For employers offering such coverage to all full-time employees but not part-time employees, the credit shall be in an amount equal to twenty per cent of the cost of providing health benefits, provided such amount shall not exceed eight hundred dollars per employee per year in the case of a policy covering an individual employee, one thousand six hundred dollars per employee per year in the case of a policy

covering an employee and only one other individual, or two thousand four hundred dollars per employee per year in the case of a policy covering the employee and the family of such employee.

(2) For employers offering such coverage to all full-time and part-time employees, the credit shall be in an amount equal to twenty-five per cent of the cost of providing health benefits, provided such amount shall not exceed one thousand dollars per employee per year in the case of a policy covering an individual employee, two thousand dollars per employee per year in the case of a policy covering an employee and only one other individual, or three thousand dollars per employee per year in the case of a policy covering an employee and the family of such employee.

(e) In the event the individual claiming a credit under this section owes less than the value of the credit allowed under this section, the individual shall be entitled to a refund from the state in an amount equal to the amount of the unused credit.

(f) The dollar amount of the credits in subsections (c) and (d) of this section shall be annually indexed to the consumer price index for medical care.

Sec. 7. (NEW) (*Effective July 1, 2007*) (a) For purposes of this section:

(1) "Employer" means any person, firm, business, educational institution, nonprofit agency, corporation, limited liability company or any other entity which, on at least fifty per cent of its working days during the preceding twelve months, employed not more than fifty eligible employees, the majority of whom were employed within the state of Connecticut, but shall not include the state or any political subdivision of the state;

(2) "Full-time employee" means any person employed by an employer for thirty hours or more a week in a full-time position; and

(3) "Part-time employee" means any person employed by an

employer for less than thirty hours a week in a part-time position.

(b) There is hereby established a tax credit to assist employers with providing health insurance to their employees to achieve the goal of ensuring greater access to health insurance for residents of this state. Any employer that elects to claim such tax credit shall submit a copy of its health insurance plan to the Connecticut Connector. If said Connecticut Connector certifies that such plan meets or exceeds the standards for the enhanced health care plan established pursuant to section 2 of this act, the Connecticut Connector shall issue a certificate indicating such fact.

(c) (1) There shall be allowed a credit against the tax imposed under chapter 208 and chapter 213a of the general statutes on any corporation or entity subject to either tax, provided such employer has (A) obtained a certificate from the Connecticut Connector in accordance with this section, and (B) pays at least seventy per cent of the cost of an employee's benefits and fifty per cent of the cost of dependents' benefits for full-time employees.

(2) For employers offering such coverage to all full-time employees but not to all part-time employees, the credit shall be in an amount equal to thirty per cent of the cost of providing health care benefits, provided such amount shall not exceed one thousand two hundred dollars per employee per year in the case of a policy covering an individual employee, two thousand four hundred dollars per employee per year in the case of a policy covering an employee and only one other individual, or three thousand six hundred dollars per employee per year in the case of a policy covering an employee and the family of such employee.

(3) For employers offering such coverage to all full-time and all part-time employees, the credit shall be in an amount equal to thirty-five per cent of the cost of providing health care benefits, provided such amount shall not exceed one thousand four hundred dollars per employee per year in the case of a policy covering an individual

employee, two thousand eight hundred dollars per employee per year in the case of a policy covering an employee and only one other individual, or four thousand two hundred dollars per year in the case of a policy covering an employee and the family of such employee.

(4) In the event the employer owes less than the value of the credit allowed under this subsection, the employer shall be entitled to a refund from the state in an amount equal to the amount of the unused credit.

(d) An employer qualifying under subsection (c) of this section that is a limited liability company, limited liability partnership, limited partnership or S corporation, as defined in section 12-284b of the general statutes, may distribute a credit to its members and such members shall be eligible to use such credit against the tax imposed under chapter 229 of the general statutes. The total credit that may be distributed shall not be greater than the following:

(1) For employers offering such coverage to all full-time employees but not to part-time employees, the credit shall be in an amount equal to thirty per cent of the cost of providing health benefits, provided such amount shall not exceed one thousand two hundred dollars per employee per year in the case of a policy covering an individual employee, two thousand four hundred dollars per employee per year in the case of a policy covering an employee and only one other individual, or three thousand six hundred dollars per employee per year in the case of a policy covering an employee and the family of such employee.

(2) For employers offering such coverage to all full-time and all part-time employees, the credit shall be in an amount equal to thirty-five per cent of the cost of providing health care to a part-time employee, provided such amount shall not exceed one thousand four hundred fifty dollars per employee per year in the case of a policy covering an individual employee, two thousand eight hundred dollars per employee per year in the case of a policy covering an employee

and only one other individual, or four thousand two hundred dollars per employee per year in the case of a policy covering an employee and the family of such employee.

(e) In the event the individual claiming a credit under this section owes less than the value of the credit allowed under this section, the individual shall be entitled to a refund from the state in an amount equal to the amount of the unused credit.

(f) The dollar amount of credits in subsections (c) and (d) of this section shall be annually indexed to the consumer price index for medical care.

Sec. 8. (NEW) (*Effective July 1, 2007*) (a) For purposes of this section:

(1) "Employer" means any person, firm, business, educational institution, nonprofit agency, corporation, limited liability company or any other entity which, on at least fifty per cent of its working days during the preceding twelve months, employed not more than fifty eligible employees, the majority of whom were employed within the state of Connecticut, but shall not include the state or any political subdivision of the state;

(2) "Full-time employee" means any person employed by an employer for thirty hours or more a week in a full-time position; and

(3) "Part-time employee" means any person employed by an employer for less than thirty hours a week in a part-time position.

(b) There is hereby established a tax credit to assist employers with providing health insurance to their employees to achieve the goal of ensuring greater access to health insurance for residents of this state. Any eligible employer that elects to claim such tax credit shall submit a copy of its health insurance plan to the Connecticut Connector. If said Connecticut Connector certifies that such plan meets or exceeds the minimum benefit plan provided to state employees pursuant to the State Employees' Bargaining Agent Coalition (SEBAC) agreement, the

Connecticut Connector shall issue a certificate indicating such fact.

(c) (1) There shall be allowed a credit against the tax imposed under chapter 208 and chapter 213a of the general statutes on any corporation or entity subject to either tax, provided such employer (A) has obtained a certificate from the Connecticut Connector in accordance with this section, and (B) pays at least seventy per cent of the cost of an employee's benefits and fifty per cent of the cost of dependents' benefits for full-time employees.

(2) For employers offering such coverage to all full-time employees but not to all part-time employees, the credit shall be in an amount equal to forty per cent of the cost of providing health care benefits, provided such amount shall not exceed one thousand six hundred dollars per employee per year in the case of a policy covering an individual employee, three thousand two hundred dollars per employee per year in the case of a policy covering an employee and only one other individual, or four thousand eight hundred dollars per employee per year in the case of a policy covering an employee and the family of such employee.

(3) For employers offering such coverage to all full-time and all part-time employees, the credit shall be in an amount equal to forty-five per cent of the cost of providing health care benefits provided such amount shall not exceed one thousand eight hundred dollars per employee per year in the case of a policy covering an individual employee, three thousand six hundred dollars per employee per year in the case of a policy covering an employee and only one other individual, or five thousand four hundred dollars per part-time employee in the case of a policy covering a family.

(4) In the event the employer owes less than the value of the credit allowed under this subsection, the employer shall be entitled to a refund from the state in an amount equal to the amount of the unused tax credit.

(d) An employer qualifying under subsection (c) of this section that is a limited liability company, limited liability partnership, limited partnership or S corporation, as defined in section 12-284b of the general statutes, may distribute a credit to its members and such members shall be eligible to use such credit against the tax imposed under chapter 229 of the general statutes. The total credit that may be distributed shall not be greater than the following:

(1) For employers offering such coverage to all full-time employees but not to all part-time employees, an amount equal to forty per cent of the cost of providing health care benefits, provided such amount shall not exceed one thousand six hundred dollars per employee per year in the case of a policy covering an individual employee, three thousand two hundred dollars per employee per year in the case of a policy covering an employee and only one other individual, or four thousand eight hundred dollars per employee per year in the case of a policy covering an employee and the family of such employee.

(2) For employers offering such coverage to all full-time and all part-time employees, an amount equal to forty-five per cent of the cost of providing health care benefits, provided such amount shall not exceed one thousand eight hundred dollars per employee per year in the case of a policy covering an individual employee, three thousand six hundred dollars per employee per year in the case of a policy covering an employee and only one other individual, or five thousand four hundred dollars per employee per year in the case of a policy covering an employee and the family of such employee.

(e) In the event the individual claiming a credit under this section owes less than the value of the credit allowed under this section, the individual shall be entitled to a refund from the state in an amount equal to the amount of the unused credit.

(f) The dollar amount of credits in subsections (c) and (d) of this section shall be annually indexed to the consumer price index for medical care.

Sec. 9. (NEW) (*Effective July 1, 2007*) (a) The Connecticut Connector shall, not later than thirty days after receipt of all relevant information provided by an employer, determine whether to certify that an employer is eligible for a tax credit pursuant to section 6, 7 or 8 of this act.

(b) Said Connecticut Connector shall provide information to employers seeking assistance with obtaining certification pursuant to this section.

Sec. 10. (NEW) (*Effective July 1, 2007*) (a) There is established the health savings account incentive program. To be eligible for payment pursuant to this section, an individual's family income may not exceed four hundred per cent of the federal poverty level. The Connecticut Connector shall annually contribute to the health savings account of any individual who resides in the state and who has a health savings account and high deductible health plan pursuant to section 223 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time to time amended, an amount determined by a sliding scale as follows:

(1) For a family income equal to or less than two hundred per cent of the federal poverty level, five hundred dollars for an individual who has contributed or received contributions of at least two thousand five hundred dollars in his or her health savings account in the previous year, one thousand dollars for a family of two who has contributed or received contributions of at least three thousand seven hundred fifty dollars in their health savings account in the previous year, or one thousand five hundred dollars for a family of three or more who has contributed or received contributions of at least five thousand dollars in their health savings account in the previous year.

(2) For a family income greater than two hundred per cent but less than three hundred per cent of the federal poverty level, four hundred dollars for an individual who has contributed or received contributions of at least two thousand five hundred dollars in his or

her health savings account in the previous year, eight hundred dollars for a family of two who has contributed or received contributions of at least three thousand seven hundred fifty dollars in their health savings account in the previous year, or one thousand two hundred dollars for a family of three or more who has contributed or received contributions of at least five thousand dollars in their health savings account in the previous year.

(3) For a family income equal to or greater than three hundred per cent but less than four hundred per cent of the federal poverty level, three hundred dollars for an individual who has contributed or received contributions of at least two thousand five hundred dollars in his or her health savings account in the previous year, six hundred dollars for a family of two who has contributed or received contributions of at least three thousand seven hundred fifty dollars in their health savings account in the previous year, or nine hundred dollars for a family of three or more who has contributed or received contributions of at least five thousand dollars in their health savings account in the previous year.

(b) The amounts specified in subdivisions (2) and (3) of subsection (a) of this section shall be annually indexed to the consumer price index for medical care.

(c) The Connecticut Connector shall make payments, in accordance with this section, by January thirtieth of any year for health savings account balances at the end of the prior calendar year. The Connecticut Connector shall establish procedures by which individuals may claim payment pursuant to this section.

Sec. 11. (NEW) (*Effective July 1, 2007*) (a) There is established the premium subsidy program. To be eligible for payment pursuant to this section, an individual (1) shall not have family income exceeding four hundred per cent of the federal poverty level, (2) shall not individually or as part of a family own a health savings account pursuant to section 223 of the Internal Revenue Code of 1986, or any subsequent

corresponding internal revenue code of the United States, as from time to time amended, and (3) shall have health care coverage under an employer-sponsored plan for which the employee pays at least five hundred dollars in premiums annually to the employee's employer if single and at least one thousand dollars in premiums annually to the employee's employer if the employee is covered by a family plan or has a nonemployer-based plan purchased through the individual market or the Connecticut Connector. The Connecticut Connector shall quarterly reimburse an individual who is eligible pursuant to this section for premiums paid in the preceding quarter as follows:

(1) For a family with income equal to or less than two hundred per cent of the federal poverty level, eighty per cent of their share of the premium, not to exceed one hundred twenty-five dollars per quarter for an individual, two hundred fifty dollars per quarter for an individual plus one dependent, or three hundred seventy-five dollars per quarter for a family.

(2) For a family with income greater than two hundred per cent but less than three hundred per cent of the federal poverty level, sixty per cent of their share of the premium, not to exceed one hundred dollars per quarter for an individual, two hundred dollars per quarter for an individual plus one dependent, or three hundred dollars per quarter for a family.

(3) For a family with income greater than three hundred per cent but less than four hundred per cent of the federal poverty level, forty per cent of their share of the premium, not to exceed seventy-five dollars per quarter for an individual, one hundred fifty dollars per quarter for an individual plus one dependent, or two hundred twenty-five dollars per quarter for a family.

(b) The Connecticut Connector shall establish procedures by which individuals may claim payment pursuant to this section.

Sec. 12. (NEW) (*Effective July 1, 2007*) The Commissioner of Social

Services shall seek a federal waiver for the purpose of (1) obtaining any available federal reimbursement for state expenditures related to the health savings account incentive program established under section 10 of this act and the subsidized premium program established under section 11 of this act, and (2) establishing a state excess cost reinsurance program for enrollees in the Connecticut Connector's affordable health care plan to allow such enrollees to obtain coverage through the Medicaid program once their insurance benefits are exhausted without having to spend down their assets.

Sec. 13. (NEW) (*Effective July 1, 2007*) No employer in this state may offer health benefit plans of lesser value to lower-paid employees than to higher-paid employees.

Sec. 14. (NEW) (*Effective July 1, 2007*) The Commissioner of Social Services shall develop a plan to implement a system of primary care case management for the delivery of health care services to all or a substantial subset of the aged, blind and disabled Medicaid beneficiaries. Said commissioner may contract with an administrative services organization to effectuate the implementation of such primary care case management system. Such plan shall include programs to improve coordination of and access to medical services, chronic disease management programs, predictive modeling to identify high risk, complex and high-cost Medicaid beneficiaries and to provide them with intensive care coordination.

Sec. 15. (NEW) (*Effective July 1, 2007*) On and after January 1, 2008, the Commissioner of Social Services shall allow aged, blind or disabled Medicaid beneficiaries to voluntarily enroll in the managed care plans available to HUSKY Plan, Part A and HUSKY Plan, Part B beneficiaries.

Sec. 16. Section 17b-267 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) If any group or association of providers of medical assistance

services wishes to have payments as provided for under sections 17b-260 to 17b-262, inclusive, 17b-264 to 17b-285, inclusive, and 17b-357 to 17b-361, inclusive, to such providers made through a national, state or other public or private agency or organization and nominates such agency or organization for this purpose, the Commissioner of Social Services is authorized to enter into an agreement with such agency or organization providing for the determination by such agency or organization, subject to such review by the Commissioner of Social Services as may be provided for by the agreement, of the payments required to be made to such providers at the rates set by the hospital cost commission, and for the making of such payments by such agency or organization to such providers. Such agreement may also include provision for the agency or organization to do all or any part of the following: With respect to the providers of services which are to receive payments through it, (1) to serve as a center for, and to communicate to providers, any information or instructions furnished to it by the Commissioner of Social Services, and to serve as a channel of communication from providers to the Commissioner of Social Services; (2) to make such audits of the records of providers as may be necessary to insure that proper payments are made under this section; and (3) to perform such other functions as are necessary to carry out the provisions of sections 17b-267 to 17b-271, inclusive.

(b) The Commissioner of Social Services shall not enter into an agreement with any agency or organization under subsection (a) of this section unless (1) he finds (A) that to do so is consistent with the effective and efficient administration of the medical assistance program, and (B) that such agency or organization is willing and able to assist the providers to which payments are made through it in the application of safeguards against unnecessary utilization of services furnished by them to individuals entitled to hospital insurance benefits under section 17b-261 and the agreement provides for such assistance, and (2) such agency or organization agrees to furnish to the Commissioner of Social Services such of the information acquired by it in carrying out its agreement under sections 17b-267 to 17b-271,

inclusive, as the Commissioner of Social Services may find necessary in performing his functions under said sections.

(c) An agreement with any agency or organization under subsection (a) of this section may contain such terms and conditions as the Commissioner of Social Services finds necessary or appropriate, may provide for advances of funds to the agency or organization for the making of payments by it under said subsection (a), and shall provide for payment by the Commissioner of Social Services of so much of the cost of administration of the agency or organization as is determined by the Commissioner of Social Services to be necessary and proper for carrying out the functions covered by the agreement.

(d) On or after July 1, 2007, each managed care plan that enters into, renews or amends a contract with the Department of Social Services pursuant to this section shall limit its administrative costs to ten per cent of payments made pursuant to such contracts. The Commissioner of Social Services shall implement policies and procedures for purposes of such certification while in the process of adopting such policies or procedures in regulation form, provided notice of intention to adopt the regulations is printed in the Connecticut Law Journal not later than twenty days after implementation and any such policies and procedures shall be valid until the time the regulations are effective. The Commissioner of Social Services may define administrative costs to exclude disease management or other value-added clinical programs administered by the managed care plans, but not to exclude utilization management, claims, member services or other nonclinical functions.

Sec. 17. (NEW) (*Effective July 1, 2007*) (a) On July 1, 2007, the Commissioner of Social Services shall increase the fee-for-service Medicaid reimbursement rates for (1) dental services by sixty per cent (2) physician services to a level equivalent to at least eighty per cent of Medicare rates in aggregate, and (3) hospital services to a level equivalent to at least ninety per cent of Medicare rates in aggregate.

The rates of reimbursement to be paid to dentists under the fee-for-service program shall be annually increased to reflect increases in the consumer price index for medical care. The rates of reimbursement to be paid to physicians and hospitals shall be annually increased to remain at such percentage of Medicare rates.

(b) On July 1, 2007, the Commissioner of Social Services shall amend each contract with a managed care plan entered into pursuant to section 17b-266 of the general statutes to require each managed care plan to increase reimbursement to dentists, physicians, and hospitals to at least the same levels specified in subsection (a) of this section.

Sec. 18. Section 17b-297 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) The commissioner, in consultation with the Children's Health Council, the Medicaid Managed Care Council and Infoline of Connecticut, shall develop mechanisms for outreach for the HUSKY Plan, Part A and Part B, including, but not limited to, development of mail-in applications and appropriate outreach materials through the Department of Revenue Services, the Labor Department, the Department of Social Services, the Department of Public Health, the Department of Children and Families and the Office of Protection and Advocacy for Persons with Disabilities.

(b) The commissioner shall include in such outreach efforts information on the Medicaid program for the purpose of maximizing enrollment of eligible children and the use of federal funds.

(c) The commissioner shall, within available appropriations, contract with severe need schools and community-based organizations for purposes of public education, outreach and recruitment of eligible children, including the distribution of applications and information regarding enrollment in the HUSKY Plan, Part A and Part B. In awarding such contracts, the commissioner shall consider the marketing, outreach and recruitment efforts of organizations. For the

purposes of this subsection, (1) "community-based organizations" shall include, but not be limited to, day care centers, schools, school-based health clinics, community-based diagnostic and treatment centers and hospitals, and (2) "severe need school" means a school in which forty per cent or more of the lunches served are served to students who are eligible for free or reduced price lunches.

(d) All outreach materials shall be approved by the commissioner pursuant to Subtitle J of Public Law 105-33.

(e) Not later than October 1, 2007, the commissioner shall award fifty grants in an amount not to exceed ten thousand dollars to community-based organizations for the purposes of public education, outreach and recruitment of eligible children, including the distribution of applications and information regarding enrollment in the HUSKY Plan, Part A and Part B.

[(e)**]** (f) Not later than January 1, 1999, and annually thereafter, the commissioner shall submit a report to the Governor and the General Assembly on the implementation of and the results of the community-based outreach program specified in subsections (a) to (c), inclusive, of this section.

Sec. 19. Subsection (a) of section 17b-261 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) Medical assistance shall be provided for any otherwise eligible person whose income, including any available support from legally liable relatives and the income of the person's spouse or dependent child, is not more than one hundred forty-three per cent, pending approval of a federal waiver applied for pursuant to subsection (d) of this section, of the benefit amount paid to a person with no income under the temporary family assistance program in the appropriate region of residence and if such person is an institutionalized individual as defined in Section 1917(c) of the Social Security Act, 42

USC 1396p(c), and has not made an assignment or transfer or other disposition of property for less than fair market value for the purpose of establishing eligibility for benefits or assistance under this section. Any such disposition shall be treated in accordance with Section 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of property made on behalf of an applicant or recipient or the spouse of an applicant or recipient by a guardian, conservator, person authorized to make such disposition pursuant to a power of attorney or other person so authorized by law shall be attributed to such applicant, recipient or spouse. A disposition of property ordered by a court shall be evaluated in accordance with the standards applied to any other such disposition for the purpose of determining eligibility. The commissioner shall establish the standards for eligibility for medical assistance at one hundred forty-three per cent of the benefit amount paid to a family unit of equal size with no income under the temporary family assistance program in the appropriate region of residence, pending federal approval, except that the medical assistance program shall provide coverage to persons under the age of nineteen up to one hundred eighty-five per cent of the federal poverty level without an asset limit. Said medical assistance program shall also provide coverage to persons under the age of nineteen and their parents and needy caretaker relatives who qualify for coverage under Section 1931 of the Social Security Act with family income up to one hundred **[**fifty**]** eighty-five per cent of the federal poverty level without an asset limit, upon the request of such a person or upon a redetermination of eligibility. Such levels shall be based on the regional differences in such benefit amount, if applicable, unless such levels based on regional differences are not in conformance with federal law. Any income in excess of the applicable amounts shall be applied as may be required by said federal law, and assistance shall be granted for the balance of the cost of authorized medical assistance. All contracts entered into on and after July 1, 1997, pursuant to this section shall include provisions for collaboration of managed care organizations with the Nurturing Families Network established

pursuant to section 17a-56. The Commissioner of Social Services shall provide applicants for assistance under this section, at the time of application, with a written statement advising them of (1) the effect of an assignment or transfer or other disposition of property on eligibility for benefits or assistance, and (2) the availability of, and eligibility for, services provided by the Nurturing Families Network established pursuant to section 17a-56.

Sec. 20. Section 17b-261 of the general statutes is amended by adding subsection (k) as follows (*Effective July 1, 2007*):

(NEW) (k) The Commissioner of Social Services, pursuant to 42 USC 1396a(r)(2), shall file an amendment to the Medicaid state plan to allow the commissioner, when making Medicaid eligibility determinations, to raise the medically needy income limit for persons who are aged, blind or disabled to an amount not to exceed one hundred fifty per cent of the federal poverty level.

Sec. 21. Section 17b-292 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) A child who resides in a household with a family income which exceeds one hundred eighty-five per cent of the federal poverty level and does not exceed three hundred per cent of the federal poverty level may be eligible for subsidized benefits under the HUSKY Plan, Part B.

(b) A child who resides in a household with a family income over three hundred per cent of the federal poverty level may be eligible for unsubsidized benefits under the HUSKY Plan, Part B.

(c) Whenever a court or family support magistrate orders a noncustodial parent to provide health insurance for a child, such parent may provide for coverage under the HUSKY Plan, Part B.

(d) A child or adult who has been determined to be eligible for benefits under either the HUSKY Plan, Part A or Part B shall remain

eligible for such plan for a period of twelve months from such child's determination of eligibility unless the child attains the age of nineteen or is no longer a resident of the state. During the twelve-month period following the date that a child is determined eligible for the HUSKY Plan, Part A or Part B, the family of such child shall comply with federal requirements concerning the reporting of information to the department, including, but not limited to, change of address information.

[(d)**]** (e) To the extent allowed under federal law, the commissioner shall not pay for services or durable medical equipment under the HUSKY Plan, Part B if the enrollee has other insurance coverage for the services or such equipment.

[(e)**]** (f) A newborn child who otherwise meets the eligibility criteria for the HUSKY Plan, Part B shall be eligible for benefits retroactive to his date of birth, provided an application is filed on behalf of the child **[**within**]** not later than thirty days **[**of**]** after such date. Any uninsured child born in a hospital in this state or in an eligible border state hospital shall be enrolled by an expedited process in the HUSKY Plan, Part B provided (1) the child's family resides in this state, and (2) a parent of such child authorizes enrollment in the program. The commissioner shall pay any premium cost such family would otherwise incur for the first two months of coverage to the managed care organization selected by the family to provide coverage for such child.

[(f)**]** (g) The commissioner shall implement presumptive eligibility for children applying for Medicaid. Such presumptive eligibility determinations shall be in accordance with applicable federal law and regulations. The commissioner shall adopt regulations, in accordance with chapter 54, to establish standards and procedures for the designation of organizations as qualified entities to grant presumptive eligibility. Qualified entities shall ensure that, at the time a presumptive eligibility determination is made, a completed application

for Medicaid is submitted to the department for a full eligibility determination. In establishing such standards and procedures, the commissioner shall ensure the representation of state-wide and local organizations that provide services to children of all ages in each region of the state.

[(g)**]** (h) The commissioner shall enter into a contract with an entity to be a single point of entry servicer for applicants and enrollees under the HUSKY Plan, Part A and Part B. The servicer shall jointly market both Part A and Part B together as the HUSKY Plan. Such servicer shall develop and implement public information and outreach activities with community programs. Such servicer shall electronically transmit data with respect to enrollment and disenrollment in the HUSKY Plan, Part B to the commissioner.

[(h)**]** (i) Upon the expiration of any contractual provisions entered into pursuant to subsection **[**(g)**]** (h) of this section, the commissioner shall develop a new contract for single point of entry services and managed care enrollment brokerage services. The commissioner may enter into one or more contractual arrangements for such services for a contract period not to exceed seven years. Such contracts shall include performance measures, including, but not limited to, specified time limits for the processing of applications, parameters setting forth the requirements for a completed and reviewable application and the percentage of applications forwarded to the department in a complete and timely fashion. Such contracts shall also include a process for identifying and correcting noncompliance with established performance measures, including sanctions applicable for instances of continued noncompliance with performance measures.

[(i)**]** (j) The single point of entry servicer shall send an application and supporting documents to the commissioner for determination of eligibility of a child who resides in a household with a family income of one hundred eighty-five per cent or less of the federal poverty level. The servicer shall enroll eligible beneficiaries in the applicant's choice

of managed care plan. Upon enrollment in a managed care plan, an eligible HUSKY Plan, Part A or Part B beneficiary shall remain enrolled in such managed care plan for twelve months from the date of such enrollment unless (1) an eligible beneficiary demonstrates good cause to the satisfaction of the commissioner of the need to enroll in a different managed care plan, or (2) the beneficiary no longer meets program eligibility requirements.

[(j)**]** (k) Not more than twelve months after the determination of eligibility for benefits under the HUSKY Plan, Part A and Part B and annually thereafter, the commissioner or the servicer, as the case may be, shall determine if the child continues to be eligible for the plan. The commissioner or the servicer shall mail an application form to each participant in the plan for the purposes of obtaining information to make a determination on eligibility. To the extent permitted by federal law, in determining eligibility for benefits under the HUSKY Plan, Part A or Part B with respect to family income, the commissioner or the servicer shall rely upon information provided in such form by the participant unless the commissioner or the servicer has reason to believe that such information is inaccurate or incomplete. The Department of Social Services shall annually review a random sample of cases to confirm that, based on the statistical sample, relying on such information is not resulting in ineligible clients receiving benefits under HUSKY Plan, Part A or Part B. The determination of eligibility shall be coordinated with health plan open enrollment periods.

[(k)**]** (l) The commissioner shall implement the HUSKY Plan, Part B while in the process of adopting necessary policies and procedures in regulation form in accordance with the provisions of section 17b-10.

[(l)**]** (m) The commissioner shall adopt regulations, in accordance with chapter 54, to establish residency requirements and income eligibility for participation in the HUSKY Plan, Part B and procedures for a simplified mail-in application process. Notwithstanding the provisions of section 17b-257b, such regulations shall provide that any

child adopted from another country by an individual who is a citizen of the United States and a resident of this state shall be eligible for benefits under the HUSKY Plan, Part B upon arrival in this state.

Sec. 22. Section 38a-567 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

Health insurance plans and insurance arrangements covering small employers and insurers and producers marketing such plans and arrangements shall be subject to the following provisions:

(1) (A) Any such plan or arrangement shall be renewable with respect to all eligible employees or dependents at the option of the small employer, policyholder or contract-holder, as the case may be, except: (i) For nonpayment of the required premiums by the small employer, policyholder or contract-holder; (ii) for fraud or misrepresentation of the small employer, policyholder or contractholder or, with respect to coverage of individual insured, the insureds or their representatives; (iii) for noncompliance with plan or arrangement provisions; (iv) when the number of insureds covered under the plan or arrangement is less than the number of insureds or percentage of insureds required by participation requirements under the plan or arrangement; or (v) when the small employer, policyholder or contractholder is no longer actively engaged in the business in which it was engaged on the effective date of the plan or arrangement.

(B) Renewability of coverage may be effected by either continuing in effect a plan or arrangement covering a small employer or by substituting upon renewal for the prior plan or arrangement the plan or arrangement then offered by the carrier that most closely corresponds to the prior plan or arrangement and is available to other small employers. Such substitution shall only be made under conditions approved by the commissioner. A carrier may substitute a plan or arrangement as stated above only if the carrier effects the same substitution upon renewal for all small employers previously covered under the particular plan or arrangement, unless otherwise approved

by the commissioner. The substitute plan or arrangement shall be subject to the rating restrictions specified in this section on the same basis as if no substitution had occurred, except for an adjustment based on coverage differences.

(C) Notwithstanding the provisions of this subdivision, any such plan or arrangement, or any coverage provided under such plan or arrangement may be rescinded for fraud, material misrepresentation or concealment by an applicant, employee, dependent or small employer.

(D) Any individual who was not a late enrollee at the time of his or her enrollment and whose coverage is subsequently rescinded shall be allowed to reenroll as of a current date in such plan or arrangement subject to any preexisting condition or other provisions applicable to new enrollees without previous coverage. On and after the effective date of such individual's reenrollment, the small employer carrier may modify the premium rates charged to the small employer for the balance of the current rating period and for future rating periods, to the level determined by the carrier as applicable under the carrier's established rating practices had full, accurate and timely underwriting information been supplied when such individual initially enrolled in the plan. The increase in premium rates allowed by this provision for the balance of the current rating period shall not exceed twenty-five per cent of the small employer's current premium rates. Any such increase for the balance of said current rating period shall not be subject to the rate limitation specified in subdivision (6) of this section. The rate limitation specified in this section shall otherwise be fully applicable for the current and future rating periods. The modification of premium rates allowed by this subdivision shall cease to be permitted for all plans and arrangements on the first rating period commencing on or after July 1, 1995.

(2) Except in the case of a late enrollee who has failed to provide evidence of insurability satisfactory to the insurer, the plan or

arrangement may not exclude any eligible employee or dependent who would otherwise be covered under such plan or arrangement on the basis of an actual or expected health condition of such person. No plan or arrangement may exclude an eligible employee or eligible dependent who, on the day prior to the initial effective date of the plan or arrangement, was covered under the small employer's prior health insurance plan or arrangement pursuant to workers' compensation, continuation of benefits pursuant to federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-2721, as amended) or other applicable laws. The employee or dependent must request coverage under the new plan or arrangement on a timely basis and such coverage shall terminate in accordance with the provisions of the applicable law.

(3) (A) For rating periods commencing on or after October 1, 1993, and prior to July 1, 1994, the premium rates charged or offered for a rating period for all plans and arrangements may not exceed one hundred thirty-five per cent of the base premium rate for all plans or arrangements.

(B) For rating periods commencing on or after July 1, 1994, and prior to July 1, 1995, the premium rates charged or offered for a rating period for all plans or arrangements may not exceed one hundred twenty per cent of the base premium rate for such rating period. The provisions of this subdivision shall not apply to any small employer who employs more than twenty-five eligible employees.

(4) For rating periods commencing on or after October 1, 1993, and prior to July 1, 1995, the percentage increase in the premium rate charged to a small employer, who employs not more than twenty-five eligible employees, for a new rating period may not exceed the sum of:

(A) The percentage change in the base premium rate measured from the first day of the prior rating period to the first day of the new rating period;

(B) An adjustment of the small employer's premium rates for the prior rating period, and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer, such adjustment (i) not to exceed ten per cent annually for the rating periods commencing on or after October 1, 1993, and prior to July 1, 1994, and (ii) not to exceed five per cent annually for the rating periods commencing on or after July 1, 1994, and prior to July 1, 1995; and

(C) Any adjustments due to change in coverage or change in the case characteristics of the small employer, as determined from the small employer carrier's applicable rate manual.

(5) (A) With respect to plans or arrangements issued on or after July 1, **[**1995**]** 2008, the premium rates charged or offered to small employers shall be established on the basis of a community rate, adjusted to reflect one or more of the following classifications:

(i) Age, provided age brackets of less than five years shall not be utilized;

(ii) Gender;

(iii) Geographic area, provided an area smaller than a county shall not be utilized;

(iv) Industry, provided the rate factor associated with any industry classification shall not vary from the arithmetic average of the highest and lowest rate factors associated with all industry classifications by greater than fifteen per cent of such average, and provided further, the rate factors associated with any industry shall not be increased by more than five per cent per year;

(v) Group size, provided the highest rate factor associated with group size shall not vary from the lowest rate factor associated with group size by a ratio of greater than 1.25 to 1.0;

(vi) Administrative cost savings resulting from the administration of an association group plan or a plan written pursuant to section 5-259, provided the savings reflect a reduction to the small employer carrier's overall retention that is measurable and specifically realized on items such as marketing, billing or claims paying functions taken on directly by the plan administrator or association, except that such savings may not reflect a reduction realized on commissions;

(vii) Savings resulting from a reduction in the profit of a carrier who writes small business plans or arrangements for an association group plan or a plan written pursuant to section 5-259 provided any loss in overall revenue due to a reduction in profit is not shifted to other small employers; **[**and**]**

(viii) Family composition, provided the small employer carrier shall utilize only one or more of the following billing classifications: (I) Employee; (II) employee plus family; (III) employee and spouse; (IV) employee and child; (V) employee plus one dependent; and (VI) employee plus two or more dependents<u>; and</u>

<u>(ix) Status as smoker or nonsmoker</u>.

(B) The small employer carrier shall quote premium rates to small employers after receipt of all demographic rating classifications of the small employer group. No small employer carrier may inquire regarding health status or claims experience of the small employer or its employees or dependents prior to the quoting of a premium rate.

(C) The provisions of subparagraphs (A) and (B) of this subdivision shall apply to plans or arrangements issued on or after July 1, 1995. The provisions of subparagraphs (A) and (B) of this subdivision shall apply to plans or arrangements issued prior to July 1, 1995, as of the date of the first rating period commencing on or after that date, but no later than July 1, 1996.

(6) For any small employer plan or arrangement on which the

premium rates for employee and dependent coverage or both, vary among employees, such variations shall be based solely on age and other demographic factors permitted under subparagraph (A) of subdivision (5) of this section and such variations may not be based on health status, claim experience, or duration of coverage of specific enrollees. Except as otherwise provided in subdivision (1) of this section, any adjustment in premium rates charged for a small employer plan or arrangement to reflect changes in case characteristics prior to the end of a rating period shall not include any adjustment to reflect the health status, medical history or medical underwriting classification of any new enrollee for whom coverage begins during the rating period.

(7) For rating periods commencing prior to July 1, 1995, in any case where a small employer carrier utilized industry classification as a case characteristic in establishing premium rates, the rate factor associated with any industry classification shall not vary from the arithmetical average of the highest and lowest rate factors associated with all industry classifications by greater than fifteen per cent of such average.

(8) Differences in base premium rates charged for health benefit plans by a small employer carrier shall be reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans.

(9) For rating periods commencing prior to July 1, 1995, in any case where an insurer issues or offers a policy or contract under which premium rates for a specific small employer are established or adjusted in part based upon the actual or expected variation in claim costs or actual or expected variation in health conditions of the employees or dependents of such small employer, the insurer shall make reasonable disclosure of such rating practices in solicitation and sales materials utilized with respect to such policy or contract.

(10) If a small employer carrier denies coverage to a small employer,

the small employer carrier shall promptly offer the small employer the opportunity to purchase a special health care plan or a small employer health care plan, as appropriate. If a small employer carrier or any producer representing that carrier fails, for any reason, to offer such coverage as requested by a small employer, that small employer carrier shall promptly offer the small employer an opportunity to purchase a special health care plan or a small employer health care plan, as appropriate.

(11) No small employer carrier or producer shall, directly or indirectly, engage in the following activities:

(A) Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer, except the provisions of this subparagraph shall not apply to information provided by a small employer carrier or producer to a small employer regarding the carrier's established geographic service area or a restricted network provision of a small employer carrier; or

(B) Encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer.

(12) No small employer carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation or geographic area of the small employer. A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to a producer, if any, for the sale of a special or a small employer health care plan. No small employer carrier shall terminate, fail to renew or limit its contract or agreement of representation with a producer for any reason related to the health status, claims experience,

occupation, or geographic location of the small employers placed by the producer with the small employer carrier.

(13) No small employer carrier or producer shall induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

(14) Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reasons for the denial.

(15) No small employer carrier or producer shall disclose (A) to a small employer the fact that any or all of the eligible employees of such small employer have been or will be reinsured with the pool, or (B) to any eligible employee or dependent the fact that he has been or will be reinsured with the pool.

(16) If a small employer carrier enters into a contract, agreement or other arrangement with another party to provide administrative, marketing or other services related to the offering of health benefit plans to small employers in this state, the other party shall be subject to the provisions of this section.

(17) The commissioner may adopt regulations in accordance with the provisions of chapter 54 setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers.

(18) Each small employer carrier shall maintain at its principle place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrates that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles. Each small employer carrier shall file with the commissioner annually, on or before March

fifteenth, an actuarial certification certifying that the carrier is in compliance with this part and that the rating methods have been derived using recognized actuarial principles consistent with the provisions of sections 38a-564 to 38a-573, inclusive. Such certification shall be in a form and manner and shall contain such information, as determined by the commissioner. A copy of the certification shall be retained by the small employer carrier at its principle place of business. Any information and documentation described in this subdivision but not subject to the filing requirement shall be made available to the commissioner upon his request. Except in cases of violations of sections 38a-564 to 38a-573, inclusive, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the commissioner to persons outside of the department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

(19) The commissioner may suspend all or any part of this section relating to the premium rates applicable to one or more small employers for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner that either the suspension is reasonable in light of the financial condition of the carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

(20) For rating periods commencing prior to July 1, 1995, a small employer carrier shall quote premium rates to any small employer within thirty days after receipt by the carrier of such employer's completed application.

(21) Any violation of subdivisions (10) to (16), inclusive, and any regulations established under subdivision (17) of this section shall be an unfair and prohibited practice under sections 38a-815 to 38a-830, inclusive.

(22) With respect to plans or arrangements issued pursuant to subsection (i) of section 5-259, or by an association group plan, at the

option of the Comptroller or the administrator of the association group plan, the premium rates charged or offered to small employers purchasing health insurance shall not be subject to this section, provided (A) the plan or plans offered or issued cover such small employers as a single entity and cover not less than ten thousand eligible individuals on the date issued, (B) each small employer is charged or offered the same premium rate with respect to each eligible individual and dependent, and (C) the plan or plans are written on a guaranteed issue basis.

Sec. 23. (NEW) (*Effective July 1, 2007*) There is established, within existing appropriations, a Quit for Good program, which shall be a smoking cessation program administered by the Department of Public Health. The department shall contract with one or more entities to implement the program, which shall (1) promote smoking cessation among unserved or underserved populations, (2) educate the public regarding the health complications relating to smoking, (3) educate the public regarding methods of quitting smoking, (4) provide counseling and referral services for treatment, and (5) establish a system to track and monitor all individuals receiving smoking cessation assistance in the program. For purposes of this section, "unserved or underserved populations" means individuals who are at or below two hundred per cent of the federal poverty level and without health insurance that comprehensively covers smoking cessation.

Sec. 24. Subsection (a) of section 12-202a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) Each health care center, as defined in section 38a-175, that is governed by sections 38a-175 to 38a-192, inclusive, shall pay a tax to the Commissioner of Revenue Services for the calendar year commencing on January 1, **[**1995**]** 2008, and annually thereafter, at the rate of one and **[**three-quarters**]** one-half per cent of the total net direct subscriber charges received by such health care center during each

such calendar year on any new or renewal contract or policy approved by the Insurance Commissioner under section 38a-183. Such payment shall be in addition to any other payment required under section 38a-48.

Sec. 25. Subdivision (37) of subsection (a) of section 12-407 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007, and applicable to sales occurring on and after July 1, 2007*):

(37) "Services" for purposes of subdivision (2) of this subsection, means:

(A) Computer and data processing services, including, but not limited to, time, programming, code writing, modification of existing programs, feasibility studies and installation and implementation of software programs and systems even where such services are rendered in connection with the development, creation or production of canned or custom software or the license of custom software, and exclusive of services rendered in connection with the creation, development hosting or maintenance of all or part of a web site which is part of the graphical, hypertext portion of the Internet, commonly referred to as the World Wide Web;

(B) Credit information and reporting services;

(C) Services by employment agencies and agencies providing personnel services;

(D) Private investigation, protection, patrol work, watchman and armored car services, exclusive of (i) services of off-duty police officers and off-duty firefighters, and (ii) coin and currency services provided to a financial services company by or through another financial services company. For purposes of this subparagraph, "financial services company" has the same meaning as provided under subparagraphs (A) to (H), inclusive, of subdivision (6) of subsection (a)

of section 12-218b;

(E) Painting and lettering services;

(F) Photographic studio services;

(G) Telephone answering services;

(H) Stenographic services;

(I) Services to industrial, commercial or income-producing real property, including, but not limited to, such services as management, electrical, plumbing, painting and carpentry and excluding any such services rendered in the voluntary evaluation, prevention, treatment, containment or removal of hazardous waste, as defined in section 22a-115, or other contaminants of air, water or soil, provided income-producing property shall not include property used exclusively for residential purposes in which the owner resides and which contains no more than three dwelling units, or a housing facility for low and moderate income families and persons owned or operated by a nonprofit housing organization, as defined in subdivision (29) of section 12-412;

(J) Business analysis, management, management consulting and public relations services, excluding (i) any environmental consulting services, (ii) any training services provided by an institution of higher education licensed or accredited by the Board of Governors of Higher Education pursuant to section 10a-34, and (iii) on and after January 1, 1994, any business analysis, management, management consulting and public relations services when such services are rendered in connection with an aircraft leased or owned by a certificated air carrier or in connection with an aircraft which has a maximum certificated take-off weight of six thousand pounds or more;

(K) Services providing "piped-in" music to business or professional establishments;

(L) Flight instruction and chartering services by a certificated air carrier on an aircraft, the use of which for such purposes, but for the provisions of subdivision (4) of section 12-410 and subdivision (12) of section 12-411, would be deemed a retail sale and a taxable storage or use, respectively, of such aircraft by such carrier;

(M) Motor vehicle repair services, including any type of repair, painting or replacement related to the body or any of the operating parts of a motor vehicle;

(N) Motor vehicle parking, including the provision of space, other than metered space, in a lot having thirty or more spaces, excluding (i) space in a seasonal parking lot provided by a person who is exempt from taxation under this chapter pursuant to subdivision (1), (5) or (8) of section 12-412, (ii) space in a parking lot owned or leased under the terms of a lease of not less than ten years' duration and operated by an employer for the exclusive use of its employees, (iii) valet parking provided at any airport, and (iv) space in municipally-operated railroad parking facilities in municipalities located within an area of the state designated as a severe nonattainment area for ozone under the federal Clean Air Act or space in a railroad parking facility in a municipality located within an area of the state designated as a severe nonattainment area for ozone under the federal Clean Air Act owned or operated by the state on or after April 1, 2000;

(O) Radio or television repair services;

(P) Furniture reupholstering and repair services;

(Q) Repair services to any electrical or electronic device, including, but not limited to, equipment used for purposes of refrigeration or air-conditioning;

(R) Lobbying or consulting services for purposes of representing the interests of a client in relation to the functions of any governmental entity or instrumentality;

(S) Services of the agent of any person in relation to the sale of any item of tangible personal property for such person, exclusive of the services of a consignee selling works of art, as defined in subsection (b) of section 12-376c, or articles of clothing or footwear intended to be worn on or about the human body other than (i) any special clothing or footwear primarily designed for athletic activity or protective use and which is not normally worn except when used for the athletic activity or protective use for which it was designed, and (ii) jewelry, handbags, luggage, umbrellas, wallets, watches and similar items carried on or about the human body but not worn on the body in the manner characteristic of clothing intended for exemption under subdivision (47) of section 12-412, under consignment, exclusive of services provided by an auctioneer;

(T) Locksmith services;

(U) Advertising or public relations services, including layout, art direction, graphic design, mechanical preparation or production supervision, not related to the development of media advertising or cooperative direct mail advertising;

(V) Landscaping and horticulture services;

(W) Window cleaning services;

(X) Maintenance services;

(Y) Janitorial services;

(Z) Exterminating services;

(AA) Swimming pool cleaning and maintenance services;

(BB) Miscellaneous personal services included in industry group 729 in the Standard Industrial Classification Manual, United States Office of Management and Budget, 1987 edition, or U.S. industry 532220, 812191, 812199 or 812990 in the North American Industrial

Classification System United States Manual, United States Office of Management and Budget, 1997 edition, exclusive of (i) services rendered by massage therapists licensed pursuant to chapter 384a, and (ii) services rendered by an electrologist licensed pursuant to chapter 388;

(CC) Any repair or maintenance service to any item of tangible personal property including any contract of warranty or service related to any such item;

(DD) Business analysis, management or managing consulting services rendered by a general partner, or an affiliate thereof, to a limited partnership, provided (i) the general partner, or an affiliate thereof, is compensated for the rendition of such services other than through a distributive share of partnership profits or an annual percentage of partnership capital or assets established in the limited partnership's offering statement, and (ii) the general partner, or an affiliate thereof, offers such services to others, including any other partnership. As used in this subparagraph "an affiliate of a general partner" means an entity which is directly or indirectly owned fifty per cent or more in common with a general partner;

(EE) Notwithstanding the provisions of section 12-412, except subdivision (87) of said section 12-412, patient care services, as defined in subdivision (29) of this subsection by a hospital, except that "sale" and "selling" does not include such patient care services for which payment is received by the hospital during the period commencing July 1, 2001, and ending June 30, 2003;

[(FF) Health and athletic club services, exclusive of (i) any such services provided without any additional charge which are included in any dues or initiation fees paid to any such club, which dues or fees are subject to tax under section 12-543, (ii) any such services provided by a municipality or an organization that is described in Section 501(c) of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time

to time amended, and (iii) yoga instruction provided at a yoga studio.**]**

(FF) Services rendered by any person related to the sale of surgical and nonsurgical cosmetic medical procedures which are directed at improving appearance and which do not meaningfully promote the proper function of the body or prevent or treat illness or disease, including, but not limited to, cosmetic surgery, hair transplants, cosmetic injections, cosmetic soft tissue fillers, dermabrasion and chemical peel, laser hair removal, laser skin resurfacing, laser treatment of leg veins, sclerotherapy and cosmetic dentistry. "Cosmetic medical procedure" does not include reconstructive surgery or dentistry, including any surgery or dentistry performed on abnormal structures caused by or related to congenital defects, developmental abnormalities, trauma, infection, tumors or disease, or procedures to improve function or give a more normal appearance. "Cosmetic surgery" means the surgical reshaping of normal structures on the body to improve the body image, self-esteem or appearance of an individual.

Sec. 26. Section 12-412 of the general statutes is amended by adding subdivision (117) as follows (*Effective July 1, 2007, and applicable to sales occurring on and after July 1, 2007*):

(NEW) (117) Dues and fees paid to health and fitness centers if the dues and fees are paid solely for health benefit activities.

Sec. 27. Section 38a-497 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

Every individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, amended or renewed in this state on or after **[**October 1, 1982**]** July 1, 2007, shall provide that coverage of a child shall terminate no earlier than the policy anniversary date on or after whichever of the following occurs first, the date on which the child marries **[**, ceases to be a dependent of the

policyholder, attains the age of nineteen if the child is not a full-time student at an accredited institution,**]** or attains the age of **[**twenty-three**]** twenty-six. **[**if the child is a full-time student at an accredited institution.**]**

Sec. 28. (NEW) (*Effective July 1, 2007*) (a) No insurer, health care center, hospital and medical service corporation or other entity delivering, issuing for delivery, renewing, continuing or amending any individual health insurance policy in this state on or after October 1, 2007, shall deliver or issue for delivery in this state any policy providing limited benefit coverage unless the applicant for such coverage signs a statement on the application form that confirms that such applicant is covered under another health benefits plan contract or policy.

(b) Each individual health insurance policy, subscriber contract or certificate of coverage delivered or issued for delivery in this state on or after October 1, 2007, that provides limited benefit coverage shall include the following statement printed in capital letters not less than twelve-point bold face type and located in a conspicuous manner on such policy, contract or certificate:

"THIS LIMITED HEALTH BENEFITS PLAN DOES NOT PROVIDE COMPREHENSIVE MEDICAL COVERAGE. IT IS A BASIC OR LIMITED BENEFITS POLICY AND CONTAINS SPECIFIC DOLLAR LIMITS THAT WILL BE PAID FOR MEDICAL SERVICES WHICH MAY NOT BE EXCEEDED. IF THE COST OF SERVICES EXCEEDS THOSE LIMITS, THE BENEFICIARY AND NOT THE INSURER IS RESPONSIBLE FOR PAYMENT OF THE EXCESS AMOUNTS."

(c) For the purposes of this section, "limited benefit coverage" means an insurance policy that is designed, advertised and marketed to supplement major medical insurance and that includes accident only, dental only, vision only, disability income only, fixed or hospital indemnity, specified disease insurance, credit insurance, Taft-Hartley trusts or that covers more than a single disease or service but has an

aggregate limit less than one hundred thousand dollars or a per service or per condition limit of less than twenty thousand dollars.

Sec. 29. (NEW) (*Effective July 1, 2007*) (a) No insurer, health care center, hospital and medical service corporation or other entity delivering, issuing for delivery, renewing, continuing or amending any group health insurance policy in this state on or after October 1, 2007, shall deliver or issue for delivery in this state any policy providing limited benefit coverage unless each employee electing such coverage confirms, in writing, that such employee is covered under another health benefits plan contract or policy. Each employer that offers a group health insurance policy that provides limited benefit coverage to its employees shall (1) have each employee electing such coverage sign a statement that confirms that such employee is covered under another health benefits plan contract or policy, and (2) submit such statement to such insurer, health care center, hospital and medical service corporation or other entity.

(b) Each group health insurance policy, subscriber contract or certificate of coverage delivered or issued for delivery in this state on or after October 1, 2007, that provides limited benefit coverage shall include the following statement printed in capital letters not less than twelve-point bold face type and located in a conspicuous manner on such policy, contract or certificate:

"THIS LIMITED HEALTH BENEFITS PLAN DOES NOT PROVIDE COMPREHENSIVE MEDICAL COVERAGE. IT IS A BASIC OR LIMITED BENEFITS POLICY AND CONTAINS SPECIFIC DOLLAR LIMITS THAT WILL BE PAID FOR MEDICAL SERVICES WHICH MAY NOT BE EXCEEDED. IF THE COST OF SERVICES EXCEEDS THOSE LIMITS, THE BENEFICIARY AND NOT THE INSURER IS RESPONSIBLE FOR PAYMENT OF THE EXCESS AMOUNTS."

(c) For the purposes of this section, "limited benefit coverage" means an insurance policy that is designed, advertised and marketed to supplement major medical insurance and that includes accident only,

dental only, vision only, disability income only, fixed or hospital indemnity, specified disease insurance, credit insurance, Taft-Hartley trusts or that covers more than a single disease or service but has an aggregate limit less than one hundred thousand dollars or a per service or per condition limit of less than twenty thousand dollars.

Sec. 30. (NEW) (*Effective July 1, 2007*) (a) There is established a permanent Commission on Healthy Lifestyles, which shall be an independent body within the Office of Health Care Access for administrative purposes only. Said commission shall: (1) By October 1, 2007, develop a marketing campaign to educate the public regarding consequences of poor health and basic measures individuals should take to ensure good health; and (2) make recommendations to the General Assembly concerning incentives to encourage personal responsibility in making healthy lifestyle choices.

(b) The commission shall consist of the Commissioners of Public Health, Education, Social Services and Health Care Access, the Insurance Commissioner, or their designees, and nine additional members as follows: One member to be appointed by the Governor, two to be appointed by the president pro tempore of the Senate, two to be appointed by the speaker of the House of Representatives, one to be appointed by the majority leader of the Senate, one to be appointed by the majority leader of the House of Representatives, one to be appointed by the minority leader of the Senate, and one to be appointed by the minority leader of the House of Representatives.

(c) Notwithstanding the provisions of subsection (c) of section 4-9a of the general statutes, the members of the commission shall serve for staggered terms. The initial members selected shall serve as follows: (1) The members appointed by the Governor and the president pro tempore of the Senate shall serve for three years; (2) the members appointed by the speaker of the House of Representatives and the majority leader of the Senate shall serve for two years; and (3) the members appointed by the majority leader and the minority leader of

the House of Representatives and the minority leader of the Senate shall serve for one year. Following the expiration of such initial terms, each subsequent appointee shall serve for a term of three years. Any vacancy shall be filled by the appointing authority for the unexpired portion of the term of the member replaced. The members shall serve without compensation for their services but shall be reimbursed for their duties.

(d) The commission shall meet at least quarterly each year. The commission, within available appropriations, may hire consultants to provide assistance with its responsibilities.

(e) The Office of Health Care Access shall, within available appropriations, contract with one or more entities to implement the marketing campaign recommended by the Commission on Healthy Lifestyles.

Sec. 31. (NEW) (*Effective July 1, 2007*) Not later than July 1, 2009, the Health Care Reform Commission, established under section 2 of this act, shall establish a nonprofit organization to be known as the Connecticut Health Quality Partnership. The Connecticut Health Quality Partnership shall: (1) Be responsible for collecting and reporting insurance claims data and other data concerning the quality of care and services provided by health plans, hospitals and health care providers for the purpose of supporting quality improvement initiatives and enabling consumers to make informed choices with respect to such providers, (2) be composed of representatives from both the private and public sectors, including, but not limited to, health insurers, hospital associations, medical societies, the Commissioners of Public Health and Social Services and consumer advocates who are not otherwise affiliated with any other members, and (3) seek funding from private and federal funding sources.

Sec. 32. (NEW) (*Effective July 1, 2007*) No physician licensed under chapter 370 of the general statutes and no hospital licensed under chapter 368v of the general statutes which does not have a contract

with a third-party payer or which provides medical services or treatment to persons who do not have health insurance coverage shall charge fees for such services or treatment that exceed two hundred per cent of those fees allowed by the federal Medicare program for such services or treatment.

Sec. 33. Subsection (d) of section 17b-192 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(d) The Commissioner of Social Services shall contract with federally qualified health centers or other primary care providers as necessary to provide medical services to eligible state-administered general assistance recipients pursuant to this section. The commissioner shall **[**, within available appropriations,**]** make payments to such centers based on their pro rata share of the cost of services provided or the number of clients served, or both. The Commissioner of Social Services shall **[**, within available appropriations,**]** make payments to other providers based on a methodology determined by the commissioner. The Commissioner of Social Services may reimburse for extraordinary medical services, provided such services are documented to the satisfaction of the commissioner. For purposes of this section, the commissioner may contract with a managed care organization or other entity to perform administrative functions, including a grievance process for recipients to access review of a denial of coverage for a specific medical service, and to operate the program in whole or in part. Provisions of a contract for medical services entered into by the commissioner pursuant to this section shall supersede any inconsistent provision in the regulations of Connecticut state agencies. A recipient who has exhausted the grievance process established through such contract and wishes to seek further review of the denial of coverage for a specific medical service may request a hearing in accordance with the provisions of section 17b-60. On July 1, 2007, the amount paid pursuant to this section to each federally qualified health center or other primary care provider shall be

increased by not less than five per cent. On July 1, 2008, and annually thereafter, such payments shall increase by not less than the percentage increase in the consumer price index.

Sec. 34. Section 12-296 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007, and applicable to sales occurring on or after July 1, 2007*):

A tax is imposed on all cigarettes held in this state by any person for sale, said tax to be at the rate of **[**seventy-five**]** eighty-two and one-half mills for each cigarette and the payment thereof shall be for the account of the purchaser or consumer of such cigarettes and shall be evidenced by the affixing of stamps to the packages containing the cigarettes as provided in this chapter.

Sec. 35. (NEW) (*Effective July 1, 2007*) (a) For purposes of this section:

(1) "Commissioner" means the Commissioner of Revenue Services;

(2) "Net revenue" means amounts billed for all health care services rendered, including room, board and ancillary services, minus (A) contractual allowances, (B) payer discounts, (C) charity care, and (D) bad debts; and

(3) "Contractual allowances" means the amount of discounts allowed to certain payers under contractual agreements.

(b) For each calendar quarter commencing on or after July 1, 2007, there is hereby imposed a health care services tax on each health care provider, mental health facility, alcohol or drug treatment facility, community health center, outpatient surgical facility, maternity home and hospital, including chronic care hospitals, licensed by the Department of Public Health, except any facility, center or hospital that is operated by the federal or state government.

(c) The health care services tax imposed in subsection (b) of this section shall be three per cent of the net revenue derived by the

taxpayer from furnishing health care services in this state.

(d) Each provider, facility, center and hospital shall, on or before the last day of October 2007, and there after on or before the last day of January, April, July and October of each year, render the commissioner a return, on forms prescribed or furnished by the commissioner, stating such information as the commissioner deems necessary for the proper administration of this section. The health care services tax imposed under this section shall be due and payable on the due date of such return. Whenever such health care services tax is not paid when due, a penalty of ten per cent of the amount due or fifty dollars, whichever is greater, shall be imposed, and interest at the rate of one per cent per month or fraction thereof shall accrue on such tax from the due date of such tax until the date of payment.

(e) The provisions of section 12-548, sections 12-550 to 12-554, inclusive, and section 12-555a of the general statutes shall apply to the provisions of this section in the same manner and with the same force and effect as if the language of said sections had been incorporated in full into this section and had expressly referred to the health care services tax imposed under this section, except to the extent that any provision is inconsistent with a provision in this section.

Sec. 36. (NEW) (*Effective July 1, 2007*) (a) On October 1, 2007, and every five years thereafter, the Office of Health Care Access shall determine the number of Connecticut residents who are not covered by a health insurance plan. If the number of uninsured residents has not decreased by fifty per cent by October 1, 2012, the Health Care Reform Commission shall determine whether it is advisable to require residents to have health insurance. Not later than January 1, 2013, the commission shall report its findings to the joint standing committee of the General Assembly having cognizance of matters relating to insurance.

(b) Not later than December 31, 2007, and annually thereafter, the Office of Health Care Access shall conduct a survey to determine the

number of Connecticut employers that are providing health care benefits to employees who reside in this state. Not later than January 1, 2008, and annually thereafter, said office shall submit a report of its findings to the joint standing committee of the General Assembly having cognizance of matters relating to insurance.

Sec. 37. (*Effective July 1, 2007*) Notwithstanding the provisions of section 4-28e of the general statutes, the sum remaining in the Tobacco and Health Trust Fund shall be transferred from said fund to the General Fund, of which twenty million dollars shall be used by the Department of Public Health for the Smoke-Free Connecticut Program.

Sec. 38. (*Effective July 1, 2007*) The sum of one million six hundred thousand dollars is appropriated to the Department of Public Health, from the General Fund, for the fiscal year ending June 30, 2008, for the purpose of providing grants in the amount of two hundred thousand dollars to eight different groups representing the interests of Connecticut employers. Such grants shall be used to train employers to effectively educate employees concerning the financial and health benefits of making lifestyle choices that promote good health, including maintaining a healthy weight and regularly exercising.

Sec. 39. (*Effective July 1, 2007*) The sum of ____ dollars is appropriated to the Department of Social Services, from the General Fund, for the fiscal year ending June 30, 2008, for the purposes of section 17 of this act.

Sec. 40. (*Effective July 1, 2007*) The sum of five hundred thousand dollars is appropriated to the Department of Social Services, from the General Fund, for the fiscal year ending June 30, 2008, for the purpose of providing grants to community-based organizations under subsection (e) of section 17b-297 of the general statutes, as amended by this act.

Sec. 41. (*Effective July 1, 2007*) The sum of one million dollars is appropriated to the Insurance Department from the General Fund, for

the fiscal year ending June 30, 2008, for the purpose of providing start-up costs for the Connecticut Connector.

Sec. 42. Section 17b-261c of the general statutes is repealed. (*Effective July 1, 2007*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2007*	New section
Sec. 2	*July 1, 2007*	New section
Sec. 3	*July 1, 2007*	New section
Sec. 4	*July 1, 2007*	New section
Sec. 5	*July 1, 2007*	New section
Sec. 6	*July 1, 2007*	New section
Sec. 7	*July 1, 2007*	New section
Sec. 8	*July 1, 2007*	New section
Sec. 9	*July 1, 2007*	New section
Sec. 10	*July 1, 2007*	New section
Sec. 11	*July 1, 2007*	New section
Sec. 12	*July 1, 2007*	New section
Sec. 13	*July 1, 2007*	New section
Sec. 14	*July 1, 2007*	New section
Sec. 15	*July 1, 2007*	New section
Sec. 16	*July 1, 2007*	17b-267
Sec. 17	*July 1, 2007*	New section
Sec. 18	*July 1, 2007*	17b-297
Sec. 19	*July 1, 2007*	17b-261(a)
Sec. 20	*July 1, 2007*	17b-261
Sec. 21	*July 1, 2007*	17b-292
Sec. 22	*July 1, 2007*	38a-567
Sec. 23	*July 1, 2007*	New section
Sec. 24	*July 1, 2007*	12-202a(a)
Sec. 25	*July 1, 2007, and applicable to sales occurring on and after July 1, 2007*	12-407(a)(37)

Sec. 26	*July 1, 2007, and applicable to sales occurring on and after July 1, 2007*	12-412
Sec. 27	*July 1, 2007*	38a-497
Sec. 28	*July 1, 2007*	New section
Sec. 29	*July 1, 2007*	New section
Sec. 30	*July 1, 2007*	New section
Sec. 31	*July 1, 2007*	New section
Sec. 32	*July 1, 2007*	New section
Sec. 33	*July 1, 2007*	17b-192(d)
Sec. 34	*July 1, 2007, and applicable to sales occurring on or after July 1, 2007*	12-296
Sec. 35	*July 1, 2007*	New section
Sec. 36	*July 1, 2007*	New section
Sec. 37	*July 1, 2007*	New section
Sec. 38	*July 1, 2007*	New section
Sec. 39	*July 1, 2007*	New section
Sec. 40	*July 1, 2007*	New section
Sec. 41	*July 1, 2007*	New section
Sec. 42	*July 1, 2007*	Repealer section

Statement of Purpose:

To reduce the number of Connecticut residents who lack health insurance benefits, to reduce the cost of health benefits, to promote the health of Connecticut residents and to improve the quality of health care services in this state.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]

Co-Sponsors: REP. O'CONNOR, 35th Dist.; REP. CHRIST, 11th Dist.
REP. HEINRICH, 101st Dist.; REP. SCHOFIELD, 16th Dist.

H.B. 6652